MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: () HCP (x) IE ( ) IC	**Response Timely Filed?** () Yes (x) No
Requestor's Name and Address The Hartford P.O. Box 4996 Syracuse, NY 13221	MDR Tracking No.: M4-04-2997-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address Med-Sport Therapy and Rehab, Inc. 4898 Little Rd. Arlington, TX 76017	Date of Injury: Employer's Name: AMR Corporation Insurance Carrier's No.: YBU 21250

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
03/31/03	04/04/03	97545-AC & 97546-AC	$896.00	$0.00

PART III: REQUESTOR'S POSITION SUMMARY

Position Summary dated 10/08/03 states in part, "…We would like to file a request for Medical Dispute Resolution regarding the above provider and dates of service. On May 27, 2003, a payment was made to Med-Sport Therapy and Rehab Ctr., Inc./Kevin Wagner LPT in the amount of $896.00 for work hardening. Based upon a peer review dated 5/21/03, work hardening was determined not reasonable and necessary…"

PART IV: RESPONDENT'S POSITION SUMMARY

No response submitted.

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

Per Rule 133.307(e) the requestors table of disputed services does not list the identical codes and modifiers billed by the respondent; therefore, reimbursement is not recommended.

PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is not entitled to refund reimbursement.

Ordered by:

	Marguerite Foster	02/17/05
Authorized Signature	Typed Name	Date of Order

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____